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Nos. 84-325 and 84-356

In the Supreme Court of the United States
OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,
v.
COMMONWEALTH OF MASSACHUSETTS,
Appellee.

THE TRAVELERS INSURANCE COMPANY,
Appellant,
v.
COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal From The Supreme Judicial Court
Of The Commonwealth Of Massachusetts

AMICUS CURIAE BRIEF OF THE STATE OF CONNECTICUT, JOINED BY THE STATES OF CALIFORNIA, KANSAS, LOUISIANA, MAINE, MARYLAND, MICHIGAN, MINNESOTA, MONTANA, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, SOUTH CAROLINA, VERMONT, WISCONSIN AND THE COMMONWEALTH OF VIRGINIA, IN SUPPORT OF APPELLEE

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INTEREST OF AMICI CURIAE

This brief is submitted by the

amici states pursuant to Supreme Court Rule 36.4.

By the McCarran-Ferguson Act, 15 U.S.C. § 1011, et seq., Congress re-established the states' right under their police powers to regulate the business of insurance. The Court has recognized the great public interest which the states have in regulating insurance and their commensurate authority: "[T]he power of the state is broad enough to take over the whole business, leaving no part for private enterprise." California Auto. Assn. v. Maloney, 341 U.S. 105, 110 (1951).

Pursuant to this authority, the amici states have regulated the business of health insurance by mandating policy

provisions, particularly in group policies. 1/ For example, the State of Connecticut mandates that the following

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1/ See generally Brummond, Federal Preemption of State Insurance Regulation Under ERISA, 62 Iowa L.Rev. 57 (1976); Manno, ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action, 52 Temp. L. Q. 51 (1979); Okin, Preemption of State Insurance Regulation by ERISA, 13 Forum 652 (1978); Rottman, Rawls, and Gollaher, National Association of Insurance Commissioners Statement on Federal Preemption of State Insurance Regulation under Section 514 of ERISA, 1 NAIC Proceedings 1977, 237 (July 21, 1976).

Amici states of Connecticut, Kansas, Maine, Maryland, Minnesota, Montana, New York, North Dakota, Virginia, and Wisconsin have mandated benefit statutes requiring that benefits be provided for mental health treatment. Conn. Gen. Stat. § 38-174d; K.S.A. 40-2,105; 24A M.R.S.A. § 2843 (Supp. 1983-84); Md. Ann. Code Art. 48A, § 477E (Michie Supp. 1984); Minn. Stat. Ann. § 62A.152 (West Supp. 1934); Mont. Code Ann. §§ 33-22-701 to 704 (1983); N.Y. Insur. Law 162 (16); N.D. Cent. Code § 26-39-03 to -04 (1978); Va. Code § 38.1-348.7 (1981); Wis. Stat. Ann. § 632.89 (West 1980 and Supp. 1983-84).

provisions be included in group health policies: Conn. Gen. Stat. §§ 38-174d (minimum mental illness benefits), 38-174e (non-termination of coverage for mentally retarded or physically handicapped dependent children), 38-174g (minimum newborn benefits), 38- 174h (certain payments to dentists), 38-174i (minimum drug overdose benefits), 38-174j (prohibition of offsets based on disability benefits), 38-174k (minimum home health care benefits), 38-1741 (minimum home health care benefits provided by a recognized nonmedical system), 38-174m (minimum loss ratio in medicare supplement policies), 38-174n (lien on workers' compensation awards), 38-174o (standards for third party prescription programs), 38-174p (offer of coverage for comprehensive rehabilitation services), 38-174q

(minimum occupational therapy benefits), 38-262b (minimum alcoholism treatment benefits), 38-262c (standards for cancellation or discontinuance of coverage), 38-262d (conversion and extension rights), 38-262f (offer of coverage for outpatient treatment of alcoholism), 38-262g (limitation on spousal premium charges), 38-262h (spousal coverage as employee and dependent), 38-262i (minimum benefits for treatment of tumors and leukemia), 38-262j (prohibition against age discrimination) and Conn. Gen. Stat., Chapter 692 (minimum benefits and policy provisions for group Comprehensive Health Care Plans).

Although the statute before the Court, Massachusetts General Laws, Chapter 175, § 47B (Section 47B),

pertains only to mandatory minimum mental health benefits, a holding of preemption under § 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C § 1144(a), would remove many other benefits and protections provided in group health insurance policies enjoyed by the citizens of various states and throw them into what some commentators have referred to as "the regulatory void." 2/ Moreover, Appellants' arguments of preemption under ERISA and the National Labor Relations Act, 29 U.S.C. § 151 et

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2/ Brummond, supra, at 117-20; Rottman, supra, at 291-97. Additionally, a holding of preemption would place both the industry and the state regulators in the difficult position of ascertaining

Continued on next page.

seq., (NLRA), if adopted by the Court, would seriously erode, if not eliminate, state supremacy in the regulation and control of the health insurance business. Thus, the amici states have substantial interests in the proper resolution of the questions presented in these appeals.

Amici states file this brief in support of the Commonwealth of Massachusetts urging that the judgment of the Supreme Judicial Court of the Commonwealth of Massachusetts be affirmed.

Footnote 2 continued:

whether the purchaser of a group health insurance policy is a qualified employee benefit plan under 29 U.S.C. §§ 1002(1) and 1003(a) to determine whether state insurance law applies to the policy. Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982), provides insight into some of the difficulties in determining whether an ERISA-qualified employee benefit plan does exist.

SUMMARY OF ARGUMENT

A statute of the Commonwealth of Massachusetts mandating that insurance companies provide minimum mental health benefits in general insurance policies which may be purchased by employee benefit plans does not relate to employee benefit plans within the meaning of 29 U.S.C. § 1144(a) as construed in Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981), and Shaw v. Delta Air Lines, Inc., _____U.S._____, 103 S.Ct. 2890 (1983).

Even if it were to be found that such a statute relates to employee benefit plans, it would be saved from preemption under the terms of ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A). This is the only result consonant with the McCarran-Ferguson Act

and ERISA, 29 U.S.C. § 1144(d), and is necessary to avoid rendering the savings clause and the deemer clause, 29 U.S.C. § 1144(b)(2)(B) surplusage.

Preemption under the National Labor Relations Act is based on two doctrines, the first preempting state regulation concerning conduct arguably protected or prohibited by the NLRA and the second preempting state regulation of conduct intended by Congress to be unregulated. The latter doctrine, which governs this case, is restricted to state regulation affecting the balance of power in collective bargaining negotiations and requires a substantial effect on such balance of power. The Massachusetts statute does not affect the balance of power in negotiations and does not have a substantial effect on the negotiation of terms of agreements

in view of its tangential relation as health legislation to the collective bargaining process and its tolerance of the alternative of providing benefits without insurance.

The doctrine governing this case recognizes also a balancing of the state interest in regulation against the potential interference with the federal interest. The state interest in health underlying the Massachusetts statute outweighs the limited effect on negotiation of terms of agreements.

Furthermore, the statute is not preempted since Congress intended to allow state regulation of insurance under the McCarran-Ferguson Act. The provision of the McCarran-Ferguson Act for application of the NLRA to the business of insurance refers only to the labor relations of insurance companies.

ARGUMENT

I.

A STATUTE OF THE COMMONWEALTH OF MASSACHUSETTS MANDATING THAT INSURANCE COMPANIES PROVIDE MINIMUM MENTAL HEALTH BENEFITS IN GENERAL HEALTH INSURANCE POLICIES WHICH MAY BE SOLD TO EMPLOYEE BENEFIT PLANS ESTABLISHED PURSUANT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, 29 U.S.C. § 1001 ET SEQ., IS NOT PREEMPTED BY 29 U.S.C. § 1144(a)

The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a), provides in part: "Except as provided in subsection (b) of this section, the provisions of this subchapter...shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...." The noted exception to this preemption clause, 29 U.S.C. § 1144(b)(2)(A), is a broad savings clause for certain state laws and reads as follows: "Except as provided in

subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

The subparagraph (B) exception to this savings clause protects only employee benefit plans and their trusts by providing that they shall not be deemed, inter alia, to be an "insurance company or other insurer...or to be engaged in the business of insurance...for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts...."

Finally, Congress clearly indicated its intent that ERISA was to have no effect on any existing federal legislation by the following language in 29 U.S.C. § 1144(d):

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

Thus, in order to hold that a state statute mandating that insurance companies provide specific health benefits in general insurance policies is preempted by ERISA, the Court must first find that the statute "relates to" employee benefit plans for the purposes of the general preemption clause, 29 U.S.C. § 1144(a). If a determination is made that the statute relates to employee welfare benefit plans, and a further finding is made that the statute does not regulate insurance within the savings clause, 29 U.S.C. § 1144(b) (2)(A), only then will the state law be held to be preempted.

A. The Statute Does Not Relate To Employee Benefit Plans

In order to come within the ambit of ERISA preemption, a state law must "relate to" an employee benefit plan.

In Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 524 (1981), a New Jersey workers' compensation statute banning pension benefit offsets based on workers' compensation was held to relate to employee benefit plans within the meaning of 29 U.S.C. § 1144(a). Having found that ERISA permitted all employee benefit plans to make pension benefit offsets based on workers' compensation, the Court concluded that the "relate to" requirement was met since the New Jersey statute directly deprived employee benefit plans of a "calculation technique" permissible under federal law. Id. at 524-25.

In Shaw v. Delta Air Lines, Inc., ____U.S.____, 103 S.Ct. 2890, 2900 (1983), the Court held that the New York Human Rights Law related to employee benefit plans to the extent that it prohibited practices (providing discriminatory benefits) permitted by federal law and that, similarly, the New York Disability Benefits Law related to employee benefit plans insofar as it required employers offering the plans to provide specific disability benefits.

All three state statutes under consideration in Alessi and Shaw did "relate to" employee benefit plans because they applied directly to the plans and gave the plans no choice but to significantly change or alter the benefits payable under the plans. In the present case, however, the state

statute applies only to insurance companies issuing general health insurance policies which may or may not be purchased by employee benefit plans. The plans clearly are not forced to comply with these laws, but may elect to become self-insurers.

That the state statute at issue here, Section 47B, applies only to group insurance policies and not employee benefit plans, is evidenced by the fact that the action was brought only against insurance carriers who issue the affected policies and not against employers or employee organizations who

offer employee benefit plans or the plans themselves. 3/

To hold that a state statute applicable only to insurance companies issuing general health insurance policies relates to employee benefit plans and is therefore within the

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3/ Indeed, the insurance carriers who raise the issue of preemption under 29 U.S.C. § 1144(a) in this action would appear to lack the requisite standing under ERISA, 29 U.S.C. § 1132(a), had they attempted to bring suit in their own right to enforce the preemption provision of ERISA. Blue Cross and Blue Shield of Kansas City v. Bell, No. 84-2255 (D. Kan., Nov. 7, 1984) (citing Tuvia Convalescent Center, Inc. v. National Union of Hospital and Health Care Employees, 717 F.2d 726 (2d Cir. 1983); Pressroom Union-Printers League Income Security Fund v. Continental Assurance Co., 700 F.2d 889 (2d Cir.), cert. denied, 104 S.Ct. 148 (1983)).

preemptive ambit of ERISA, 29 U.S.C. § 1144(a), would be an unwarranted extension of the holdings in Alessi and Shaw, and would make any state law which regulates or affects a product which an employee benefit plan may purchase or an activity in which an employee plan may engage susceptible to a claim of ERISA preemption.

B. The Statute Is Expressly Excepted From ERISA Preemption by 29 U.S.C. § 1144(b)(2)(A)

Expressly excepted from the general preemption provided in 29 U.S.C. § 1144(a) is "any law of any State which regulates insurance...." 29 U.S.C. § 1144(b)(2)(A). A state statute which mandates minimum benefits in general health insurance policies sold by insurance companies is a law which regulates insurance. Such a statute

directly regulates the relationship between the insurer and the insured and has been considered to be at the center of insurance regulation by this Court:

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement-- these were the core of the 'business of insurance.' Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was-- it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'

S.E.C. v. National Securities, 393 U.S. 453, 460 (1969).

Several factors dictate that state mandatory benefit statutes were intended by Congress to come within the savings clause exception, 29 U.S.C. § 1144(b)(2)(A), to the general preemption provision of ERISA. First, the exception is written in the broadest language possible: "any law of any State which regulates insurance...." (Emphasis added). It has been noted that this savings clause exception to the general rule of preemption was so broad as to envelop the general rule and made it necessary to include the deemer clause exception, 29 U.S.C. § 1144(b)(2)(B), to the savings clause to prevent the direct application of state insurance laws

to employee benefit plans and, in effect, require them to become insurance companies. 4/ The deemer clause would be surplusage if Congress did not consider the savings clause exception to be extremely broad.

Since the direct application of state insurance laws to employee benefit plans is prevented by the deemer clause, the savings clause must be construed to encompass insurance laws which indirectly affect employee benefit plans, or it, too, would be rendered surplusage. Wadsworth v. Whaland, 562 F.2d 70, 78 (1st Cir. 1977), cert. denied, 435 U.S. 980 (1978).

4/ Kilberg and Inman, Preemption of State Law Under ERISA: Drawing the Line Between Laws That Do and Laws that Do Not Relate to Employee Benefit Plans, 19 Forum 162, 163 (1983).

In 1979, Congress failed to enact an amendment to ERISA that would have taken state mandatory minimum coverages in insurance out of the protection of the broad exception for insurance laws. The report of the Senate Committee on Labor and Human Resources specifically stated that the proposed amendment was intended to legislatively overrule the decision of the First Circuit in Wadsworth v. Whaland, supra. The language proposed in Senate Bill 209 read as follows:

> A State insurance law which provides that a specific benefit or benefits must be provided or made available by a contract or policy of insurance issued to an employee benefit plan is a law which relates to an employee benefit plan within the meaning of subsection (a) and is not a law which regulates insurance within the meaning of subparagraph (A)...

The ERISA Improvements Act of 1979: Summary and Analysis of Consideration, United States Senate Committee on Labor and Human Resources, 1979, pp. 46, 88; see also, 125 Congressional Record 931, 937 (1979).

It is a fundamental canon of statutory construction that an act of Congress should be construed "in such a manner as to give effect to all its parts and to avoid a construction which would render a provision surplusage." Wadsworth v. Whaland, supra, 562 F.2d at 78, citing McDonald v. Thompson, 305 U.S. 263 (1938). Any other construction of these sections of 29 U.S.C. § 1144 would render either the savings or the deemer clause, or both, surplusage. If Congress had intended to preempt any law which may have an effect on employee benefit plans, both the savings clause

and the deemer clause would have been unnecessary.

All these subsections of 29 U.S.C. § 1144 underscore and reinforce the long-standing Congressional policy of state supremacy in the regulation of the insurance business set forth in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 and 1012. 5/

5/ 15 U.S.C. § 1011 reads:

> Congress declares that the continued regulation and taxation by the several states of the business of insurance is in the public interest, and that silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

15 U.S.C. § 1012 reads in pertinent part:

Continued on next page.

The general preemptive clause, 29 U.S.C. § 1144(a), is silent as to the business of insurance and can hardly be construed to relate specifically to the business of insurance. The savings clause, 29 U.S.C. § 1144(b)(2)(A), specifically refers to insurance, but only to reinforce the non-preemptive mandate of 15 U.S.C. § 1012(b). Finally, the language of 29 U.S.C. § 1144(d) clearly indicates Congressional intent that nothing in ERISA is to be construed to alter the status quo of other federal legislation.

Footnote 5 continued:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

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Thus, a fundamental canon of statutory construction, the McCarran-Ferguson Act, and the language of 29 U.S.C. § 1144(d) of ERISA, lead to the conclusion that ERISA does not preempt a state insurance statute directly applicable to insurance companies and the terms of the policies they issue.

Footnote 5 continued:

> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance....

II.

THE MASSACHUSETTS STATUTE IS NOT PREEMPTED BY THE NATIONAL LABOR RELATIONS ACT

A. The Massachusetts Statute Lacks a Substantial Effect On Negotiation Of An Agreement And The Balance Of Power In Collective Bargaining

1. Preemption Requires a Substantial Effect On Negotiation of an Agreement and the Balance of Power in Collective Bargaining

This Court has recognized two distinct approaches to preemption of state regulation by the National Labor Relations Act. The first approach preempts state regulation concerning conduct that is arguably prohibited or protected by the Act. San Diego Building Trades Council v. Garmon, 359 U.S. 236, 245 (1959). The second approach prohibits state regulation having a substantial effect on conduct

that Congress intended to be unregulated, specifically conduct involving the self-help remedies left to the parties in labor disputes. Lodge 76, International Association of Machinists v. Wisconsin Employment Relations Commission, 427 U.S. 132, 140, 147-148 (1976). The existence of these two doctrines of NLRA preemption has been confirmed by the Court on several occasions. Belknap, Inc. v. Hale, ___ U.S._____, 103 S.Ct. 3172, 3176-77 (1983); New York Telephone Co. v. New York State Department of Labor, 440 U.S. 519, 527-531 (1979); Lodge 76, International Association of Machinists v. Wisconsin Employment Relations Commission, supra, 427 U.S. at 138-140.

In Belknap, Inc. v. Hale, supra, _____U.S._____, 103 S.Ct. at

3177-81, the Court's application of the Machinists doctrine recognizes the more limited preemption under that doctrine than under Garmon. The Court requires a determination of actual effect of the state regulation on conduct intended by Congress to be unregulated. By contrast, Garmon requires only a showing of state regulation of conduct arguably protected or prohibited by the Act. There is no requirement under Garmon of establishing the practical effects of the state regulation on that conduct.

This distinction between Garmon and Machinists is clearly indicated by the Court in Belknap. Its application of Garmon is premised on state regulation of conduct arguably protected or prohibited by the Act. Id. at ___, 103 S.Ct. at 3181-82. Its application of

Machinists, however, undertakes careful inquiry into the degree of effect of the state regulation on conduct that Congress intended to be unregulated.

The Court's application of Machinists in Belknap is marked by its focus on the tangential relation of suits for damages by replacements to the federal recognition of the employer's rights with respect to hiring replacements during a strike. The Court regards the infliction of injury on third parties as tangential to the rights of employer and union to use economic weapons against each other. Id. at ____, 103 S.Ct. at 3177-78. The Court further rejects the argument of serious detriment to the employer from the conditioning of offers to the replacements in order to avoid a breach

of contract, should the employer be ordered to reinstate strikers or should a settlement require reinstatement. Id. at ___, 103 S.Ct. at 3178-79. The Court then undertakes a calculation of the effects of the state regulation on federal rights. The Court discerns no substantial impact on settlement of strikes since the employer can condition offers to replacements to avoid suits for damages. Id. at ___, 103 S.Ct. at 3180-81. The employer's risk of liability upon discharge of replacements under a settlement is viewed as minimal. The Court recognizes no greater effect on settlement than under preemption of suits for damages.

The critical aspect of the Court's approach is its reliance on calculating the degree of effect of the

state regulation on conduct intended by Congress to be unregulated. This reliance is illustrated by the Court's comparison of the effects on federal rights with and without preemption, its emphasis on the lack of substantial impact on settlement and the minimal risk of employer liability and its recognition of the tangential relation of suits for damages to federal rights. The Court does not accept, as it does under Garmon, an approach under Machinists which requires only a conclusion that the state regulation concerns conduct in an area covered by the NLRA.

In addition to the requirement of substantial effect on conduct intended by Congress to be unregulated, the Machinists doctrine requires upsetting

the balance of power between employer and union in bargaining. This is clearly the focus in Belknap. Id. at ___, 103 S.Ct. at 3177. Machinists, too, was decided on the basis of the effects of the state law on the balance of economic weapons between union and employer. Lodge 76, International Association of Machinists v. Wisconsin Employment Relations Commission, supra, 427 U.S. at 148-151. In New York Telephone Co. v. New York State Department of Labor, supra, 440 U.S. at 531-533, the Court was again concerned with the effect on the balance of economic weapons between employer and union.

With respect to the intent of Congress to leave unregulated the terms of collective bargaining agreements, the Machinists doctrine must be construed as limited to state regulation affecting

the balance of power in the negotiation of the terms of such agreements. Local 24, International Brotherhood of Teamsters v. Oliver, 358 U.S. 283, 293-294 (1959). This also follows from the Congressional concern with the balance of power in leaving unregulated the terms of agreement. In H.K. Porter Co., Inc. v. NLRB, 397 U.S. 99 (1970), the Court indicated the underlying rationale for leaving unregulated the terms of agreements. "It is implicit in the entire structure of the Act that the Board acts to oversee and referee the process of collective bargaining, leaving the results of the contest to the bargaining strengths of the parties." Id. at 107-108.

Accordingly, the Machinists doctrine requires a substantial effect on conduct intended by Congress to be

unregulated and state regulation affecting the balance of power in negotiation of terms of agreements.

2. The Massachusetts Statute Lacks a Substantial Effect On Conduct Intended by Congress to be Unregulated

a. The Massachusetts Statute Lacks a Substantial Effect on Negotiation of an Agreement

The Court's approach in Belknap leads to the conclusion that Section 47B is not preempted by the NLRA. The tangential relation of the statute to the concerns of Congress in leaving unregulated the terms of agreement must be considered. It cannot seriously be argued that Congress had in mind the preemption of health and welfare legislation totally unrelated to regulation of collective bargaining when it sought to leave the parties free to enter into terms of agreement. Moreover,

preemption here would lead to the absurd result of preempting major pieces of critical state health and safety legislation with similar tangential effects on collective bargaining agreements. For example, state legislation on automobile seat belts and prescription drugs would be preempted.

The effects of Section 47B on collective bargaining agreements are further limited by the ability of the parties to reach agreements without the use of insurance. Employee health plans may be provided without the purchase of insurance. The statute applies only when the parties have purchased insurance.

b. The Massachusetts Statute Does Not Affect the Balance of Power in Collective Bargaining

Section 47B does not affect the Congressional concern with the balance of power in leaving unregulated the terms of agreements, since it allows the parties to negotiate benefits without purchasing insurance and, even when insurance is purchased, equally restrains each party in bargaining for other benefits.

B. The Balancing Test Between State and Federal Interests Requires a Holding Against Preemption

1. The Test for Preemption Requires a Balancing of the State Interest in Regulation Against the Potential for Interference With the Federal Interest

The Machinists doctrine is subject to the exceptions under the Garmon doctrine, which have been incorporated, under Farmer v. United Brotherhood of Carpenters & Joiners of America, Local

25, 430 U.S. 290, 297-301, 304 (1977), in a test balancing the state interest in regulation against the potential for interference with federal regulation. These include the exceptions for state regulation involving deeply rooted local interests, matters of peripheral concern to the NLRA and health and safety. Id. at 296-297, 301 n. 10, 299, 302-303. The Court in Machinists indicates that its doctrine is limited by the same exceptions as is Garmon. Lodge 76, International Association of Machinists v. Wisconsin Employment Relations Commission, supra, 427 U.S. at 151. The Court's acceptance of the Garmon exceptions for purposes of the Machinists doctrine is further revealed by its reference to basic exceptions to preemption of general applicability including the exceptions for deeply rooted

local interests and matters of peripheral concern to the NLRA. Id. at 136-137.

In New York Telephone Co. v. New York State Department of Labor, supra, 440 U.S. at 533-534, the plurality accepts under Farmer a distinct state regulatory purpose as an exception to preemption. It decides against preemption on the basis of the purpose of unemployment compensation statutes to provide a state program of employment security rather than the purpose to adjust bargaining power as well as Congressional intent in federal unemployment compensation statutes to allow state regulation. Id. at 533-537. The concurring opinion also recognizes the applicability of the Garmon exceptions to the Machinists doctrine such

as the exception for deeply rooted local interests. Id. at 550.

2. The State Interest in Health Under the Massachusetts Statute Outweighs Its Limited Effect on the Federal Policy of Leaving Unregulated the Terms of Agreements

Application of the Farmer balancing test to Section 47B requires a holding against preemption. The purpose of the state statute is to promote the health of citizens, not to regulate labor relations. It falls not only within the Farmer balancing test as a separate state interest but also within the specific exceptions for deeply rooted local interests in light of the state interest in the health of its citizens and for health and safety regulations.

The potential for interference in federal interests under the NLRA is limited. First, the statute, unlike the New York statute in New York Telephone Co., does not affect the balance of power between the parties in bargaining. It permits the parties to negotiate benefits without the purchase of insurance and, even when insurance is purchased, affects the terms of the collective bargaining agreement with an equal impact on union and employer. Furthermore, Section 47B as health legislation has a tangential relation to regulation of the collective bargaining process, and preemption here would have the absurd consequence of preempting critical state health and safety legislation.

Accordingly, the state's interest in the health of its citizens outweighs the potential interference with the federal policy, and the Massachusetts statute is thus not preempted by the NLRA.

C. The McCarran-Ferguson Act Establishes a Congressional Intent to Allow the Massachusetts Statute

Section 47B is not preempted by virtue of the McCarran-Ferguson Act. The Act provides in relevant part: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b). Section 47B directly regulates insurance and insurance policies, and therefore the NLRA does not invalidate such regulation.

Attorney General v. Travelers Insurance Co., 385 Mass. 598, 613-614, 433 N.E.2d 1223, 1232 (1982). The Massachusetts statute is therefore distinguishable from the New York arbitration statute in Hamilton Life Insurance Co. v. Republic National Life Insurance Co., 408 F.2d 606, 611 (2d Cir. 1969).

McCarran-Ferguson is not rendered inapplicable on the basis of Section 4 of the Act, which provides: "Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance o...the National Labor Relations Act, or...the Fair Labor Standards Act...." 15 U.S.C. § 1014. This must be interpreted to mean that the labor relations of insurance companies are subject to the NLRA. Section 4 of McCarran-Ferguson provides for the application to

the business of insurance of the Fair Labor Standards Act. 15 U.S.C. § 1014. If this provision were construed to refer to application of the NLRA to state regulation of insurance, as opposed to the state regulation of the labor relations of insurance companies, then similarly it must be construed to refer to the application of the Fair Labor Standards Act to the state regulation of insurance, as opposed to state regulation of minimal standards of employment at insurance companies. However, the Fair Labor Standards Act, 29 U.S.C. § 201 et seq., by its very nature is concerned with the minimum wages and maximum hours in employment and therefore could have no application to state regulation of insurance. Accordingly, 15 U.S.C. § 1014 must refer to the application of the Fair Labor Standards Act to employment

standards of insurance companies and, similarly, to the application of the NLRA to labor relations of insurance companies.

This interpretation is also supported by the recognition that 15 U.S.C. § 1014 is not an exception to 15 U.S.C. § 1012(b) but merely states that nothing in the chapter affects the applicaton of the NLRA to the business of insurance. Accordingly, 15 U.S.C. § 1014 does not impose a limitation on the authorization of state regulation of insurance in 15 U.S.C. § 1012(b) but merely clarifies the irrelevance of that provision to the labor relations of insurance companies. In essence, 15 U.S.C. § 1014 confirms that the phrase "business of insurance" as used in 15 U.S.C. § 1012(b) may not be interpreted as including the labor relations of insurance companies.

CONCLUSION

For the foregoing reasons, the judgment of Supreme Judicial Court of the Commonwealth of Massachusetts should be affirmed.

RESPECTFULLY SUBMITTED,

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AMICUS CURIAE

BRIEF

No. 84-325 (19)

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant,

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee.

On Appeal from the Supreme Judicial Court for the Commonwealth of Massachusetts

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BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION, THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS AND THE AMERICAN ACADEMY OF CHILD PSYCHIATRY AS AMICI CURIAE IN SUPPORT OF APPELLEE

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INTEREST OF AMICI CURIAE

The American Psychiatric Association, founded in 1844, is the nation's largest organization of qualified doctors of medicine specializing in psychiatry. More than 30,000 of the approximately 37,000 psychiatrists in the United States are APA members. The APA has participated as amicus curiae in numerous cases involving mental health issues, including *Connecticut v. Heckler*, No. 83-2136, *Ake v. Oklahoma*, No. 83-5424, *Barefoot v. Estelle*, 103 S. Ct. 3383 (1983), *Youngberg v. Romeo*, 457 U.S. 307 (1982), *Mills v. Rogers*, 457 U.S. 291 (1981),

Estelle v. Smith, 451 U.S. 454 (1981), *Parham v. J. R.*, 442 U.S. 584 (1979), *Addington v. Texas*, 441 U.S. 418 (1979), and *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

The National Association of Private Psychiatric Hospitals is the nation's largest organization of hospitals devoted primarily to the treatment of mental illness. Founded in 1933, the Association has over 200 member-hospitals located throughout the United States. Membership in the Association is limited to facilities that have been accredited as psychiatric hospitals by the Joint Commission on the Accreditation of Hospitals. Last term the Association participated as amicus curiae in *Jefferson Parish Hospital District No. 2 v. Hyde*, 104 S.Ct. 1551 (1984).

The American Academy of Child Psychiatry is a national professional association of over 3,000 physicians who have completed a general psychiatric residency and two years of additional fellowship training in child psychiatry. Founded in 1953, the Academy, through a network of regional councils and a national consortium of mental health organizations, works closely with government agencies and mental health professionals in a variety of settings to improve the quality and delivery of mental health treatment to children and their families.

Amici are intensely interested in the outcome of this case. As organizations of providers of psychiatric care, amici believe that states must have authority to regulate the content of health insurance policies to assure that policyholders and their families receive adequate levels of coverage for mental illness. In this brief, we argue that ERISA's preemption and savings clauses should be interpreted consistently with the McCarran-Ferguson Act. Under well-defined McCarran-Ferguson principles, state mandated benefit laws are within the core of the

"business of insurance" whose regulation Congress reserved to the states. We further show that mandated benefit laws are a highly appropriate form of government regulation necessary to correct for serious distortions in the insurance market.[1]

INTRODUCTION AND SUMMARY OF ARGUMENT

This case concerns the authority of the states, consistent with ERISA, to regulate the content of health insurance policies to assure that they provide adequate levels of health coverage. The insurance industry, seeking displacement of all such regulation, focuses on the preemption provision in ERISA, and attempts to emasculate the insurance savings clause of that same statute. Massachusetts, by contrast, argues that the ERISA "savings clause" gives it complete authority to regulate employee health insurance plans so long as its laws relate to insurance generally. We believe that the savings clause, while more limited in scope than suggested by the Commonwealth, preserves a zone of permissible state regulation that includes, at its core, the type of mandated benefit laws at issue here.

ERISA's legislative history sheds little light on the insurance savings clause itself. Although the policies behind the general preemption provision are clear, those policies cannot be extended to a savings clause that, by its terms, is designed to place certain categories of state regulation—including, specifically, regulation of insurance—beyond the reach of ERISA preemption. In our view, the essence of the savings clause can best be gleaned from the McCarran-Ferguson Act, where Congress set forth definitively its view of the appropriate role of the states in regulating "the business of insurance." There is no reason to believe that the regulatory

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[1] The parties have consented to the filing of this brief. Their letters of consent have been lodged with the Clerk.

authority ceded to the states in McCarran-Ferguson was meant to be taken back in ERISA. On the contrary, juxtaposition of these two statutes suggests that, in preserving state regulation of insurance in ERISA, Congress had the McCarran-Ferguson Act very much in mind.

Under established McCarran Ferguson principles, mandated benefit laws are clearly within the "business of insurance" whose regulation Congress left to the states. These laws operate to spread the risk of loss; they directly affect the relationship between the insurer and its policyholders; and their impact is confined to entities within the insurance industry. *See, e.g., Union Labor Life Insurance v. Pireno*, 102 S. Ct. 3002 (1982). Interpreting ERISA consistently with McCarran-Ferguson thus reserves to the states the authority they need to assure that insurance policies do not leave policyholders and their families exposed to staggering financial losses for necessary medical treatment. This does not mean, however, that insurers may be subject to any type of state regulation that applies generally to insurers or that purports to regulate insurance.

Many states, for example, have enacted mandated provider laws that require insurers to make payments to particular categories of health practitioners. For all the reasons that mandated benefit laws regulate the "business of insurance" within the meaning of McCarran-Ferguson, these provider statutes do not. *See Group Life & Health Insurance Co. v. Royal Drug*, 440 U.S. 205 (1979). Although this case directly involves only mandated benefit laws, it is important for the Court to realize that a reasonable interpretation of the savings clause need not transform that provision into an exception that consumes the rule of ERISA preemption.

Interpreting ERISA's savings clause consistently with the McCarran-Ferguson Act makes far more sense than

the analysis advanced by appellant. Metropolitan's expansive reading of ERISA's preemption provision is predicated on the argument that mandated benefit laws conflict with Congress' objective of fostering uniformity in employee benefit plans. However, any alleged "disuniformities" created by mandated benefit laws are no different in kind or degree from disuniformities that may be created by various types of state regulation of insurance—for example, regulation of insurers' reserves and premiums—that appellant concedes are not preempted by ERISA. With respect to alleged disuniformities between insured and self-funded plans, moreover, Congress reasonably could have preserved state regulation of the former, while entrusting to market forces the regulation of the latter. Because of union representation and other factors, businesses large enough to self-insure are likely to provide adequate health insurance without government regulation.

Contrary to appellant's claims, mandated benefit laws represent a highly desirable form of government regulation necessary to correct distortions in the insurance market that effectively prevent the underwriting of significant health risks. In this regard, insurance protection for mental illness is a classic case of "market failure." As a result of incomplete information concerning the risks of mental illness; the threat of "adverse selection" confronting any individual insurer wishing to provide adequate coverage; and the existence of state-funded mental health facilities as a safety net for the underinsured, private insurers do not provide acceptable levels of coverage for mental illness in an unregulated environment. It is implausible to suggest that Congress intended to prohibit the states from addressing this problem when it enacted ERISA.

ARGUMENT

I. STATE MANDATED BENEFIT LAWS ARE WITHIN THE CORE OF PERMISSIBLE REGULATION OF INSURANCE RESERVED TO THE STATES THROUGH ERISA'S "SAVINGS CLAUSE"

The permissible role of the states in the regulation of health insurance plans turns on the interpretation of ERISA's "savings clause," section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A). That clause expressly limits ERISA's displacement of state law by "saving" from preemption "any law of any State which regulates *insurance*, banking, or securities." (emphasis added). Although direct regulation of employee benefit plans is precluded by section 514(b)(2)(B) of ERISA, the scope of the savings clause is otherwise complete and unqualified. On its face, section 514(b)(2)(A) preserves intact "any" state law of general applicability "which regulates insurance."

The Massachusetts statute at issue in this case, section 47B of Massachusetts General Laws Chapter 175, is plainly a state law regulating insurance. Nonetheless, it is argued here that the Massachusetts statute is preempted because the savings clause of ERISA means a great deal less than it says. Focusing on ERISA's preemption provision, section 514(a), rather than on the savings clause, section 514(b)(2)(A), appellant contends that the savings clause must be narrowly construed. Appellant reasons that, because of the importance that Congress ascribed to the preemption of state laws in general, Congress must have intended to strictly limit the operation of state regulation of insurance in particular.

In resolving this question, the Court will find little guidance in ERISA's legislative history. The relevant Committee reports, debates and hearings shed virtually no light on Congress' contemporaneous understanding of

how much state regulation of insurance was to be preserved through the savings clause. What the legislative materials do contain, of course, is extensive discussion of the purposes underlying ERISA's basic preemption provision. However, these expressions of Congressional intent, on which appellant's arguments rest, provide no real assistance in determining Congress' intentions with respect to the savings clause.

It is true that section 514(a) of ERISA, preempting all state laws "insofar as they . . . relate to any employee benefit plan," is broad in scope. The provision was intended to displace all state laws that fall within its sphere, *see Alessi v. Raybestos-Manahattan, Inc.*, 451 U.S. 504 (1981), including even state laws that are consistent with ERISA's substantive requirements, see *Shaw v. Delta Airlines Inc.*, 103 S. Ct. 2890 (1983). Nonetheless, the sphere in which section 514(a) operates was explicitly marked off by section 514(b)(2)(B). Congress' intent with respect to the basic preemption provision of ERISA says little, if anything, about the meaning of a savings clause that, by its terms, was intended to limit that provision by placing certain categories of state law—including, specifically, those regulating insurance—beyond its reach. Clearly, one must look elsewhere for evidence of Congressional purpose with respect to the savings clause.

A. ERISA's Savings Clause For Insurance Must Be Read Consistently with the McCarran-Ferguson Act

The McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.*, vests in the states primary authority for the regulation and taxing of the "business of insurance." The statute provides broadly that "the business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. 1012(a). The Act further provides for a *de facto* preemption of federal

statutes not dealing specifically with insurance. Section 1012(b) states: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business. . ."

McCarran-Ferguson was enacted in 1945 following this Court's decision in *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944). That decision, overturning prior authorities, sustained an indictment of insurance companies under the Sherman Act on grounds that the business of insurance was interstate commerce and, as such, subject to federal regulation under the Commerce Clause. Although most litigation concerning the McCarran-Ferguson Act has focused on its qualified exemption from the antitrust laws, 15 U.S.C. 1013(a) & (b), Congress' "primary concern" in enacting the statute "was to ensure that the States would continue to have the ability to tax and regulate the business of insurance." *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 217-18 (1979) (footnote omitted). *See SEC v. National Securities, Inc.*, 393 U.S. 453, 458 (1969); *Prudential Insurance Co. v. Benjamin*, 328 U.S. 408, 429 (1946).

Congress sought to maintain the states' traditional role in the regulation of insurance and to assure that those regulatory activities could be carried out free from federal interference. *SEC v. National Securities, Inc.*, 393 U.S. at 459-61. As the Court has recently explained, "the McCarran-Ferguson Act freed the States to continue to regulate and tax the business of insurance companies, in spite of the Commerce Clause." *Group Life & Health Insurance Co. v. Royal Drug, supra*, 440 U.S. at 218 n.18. The statute "operates to assure that the States are free to regulate insurance companies without fear of Commerce Clause attack." *Ibid.*

The McCarran-Ferguson Act thus represents the definitive expression of Congress' intent to allocate to the states the principal, if not exclusive, responsibility for the regulation of the business of insurance. That responsibility was not to be disturbed by Congress, other than through federal legislation dealing "specifically" with insurance. 15 U.S.C. 1012(b). Nothing in ERISA indicates that Congress intended to effect a wholesale reallocation of this responsibility, relegating the states to a minor role and transfering to the federal government virtually complete authority over the regulation of employee benefits provided through insurance programs.

"Where the field which Congress is said to have preempted has been traditionally occupied by the States . . . 'we start with the assumption that the historic police powers of the states were not to be superseded by the Federal Act unless that was the clear and manifest purpose of the Congress.'" *Jones v. Rath Packing Co.*, 430 U.S. 519 (1977), quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). This is particularly true where the field of state law is one that has been occupied by the states, not merely as a matter of tradition, but as a consequence of another act of Congress expressly ceding that authority to them. At issue here is not simply the displacement of state law, but the displacement of *federal* law as well.

What Congress gave to the states in the McCarran-Ferguson Act, Congress obviously could have taken away in ERISA. It should not be assumed that Congress did this *sub silentio*, however. Congress was certainly aware of the McCarran-Ferguson Act when it enacted ERISA; and Congress was certainly familiar with the Act's broad guarantee of state primacy in the regulation of insurance. Indeed, juxtaposition of the relevant portions of ERISA and McCarran-Ferguson suggests that Congress may have had McCarran-Ferguson very much in mind when drafting ERISA's savings clause for insurance.

Section 514(d) of ERISA provides that ERISA's preemption provision may not be construed to "alter, amend, modify, invalidate, impair, or supersede any law of the United States . . ." 29 U.S.C. 1144(d). While this savings clause is sufficient to preserve virtually any other federal statute, the McCarran-Ferguson Act poses a unique difficulty because of its own exemption for any federal law that "specifically relates to the business of insurance." 15 U.S.C. 1012(b). Because it is at least arguable that ERISA is a law that "relates to the business of insurance," some further clause in ERISA was needed to assure that McCarran-Ferguson would not be partially repealed by section 514(a). By making clear that section 514(a) does not extend to state laws regulating insurance, section 514(b)(2)(A) serves precisely this purpose.

This construction of the insurance savings clause is reinforced by ERISA's "deemer" provision, section 514(b)(2)(B). Although that provision qualifies the savings clause by forbidding direct state regulation of employee benefit plans, it does so by tracking the language of the McCarran-Ferguson Act. The provision clarifies that employee benefit plans are not to be regarded as, *inter alia*, the "business of insurance." The "business of insurance," of course, is the operative term of McCarran-Ferguson. *See* 15 U.S.C. 1012(a) & (b). As this Court has emphasized, the McCarran-Ferguson Act does not apply to the activities of insurers generally or to the insurance industry as such. *Group Life & Health Insurance Co. v. Royal Drug Co.*, *supra*, 440 U.S. at 217, 220; *SEC v. National Securities, Inc.*, *supra*, 393 U.S. at 459-60. Rather, it applies more narrowly to specific economic arrangements constituting "the business of insurance."

Even if section 514(b)(2)(A) does not, by its terms, effectuate the McCarran-Ferguson Act's proscriptions in this area, the savings clause should still be read consistently with the policies of McCarran-Ferguson. *See Wadsworth v. Whaland*, 562 F.2d 70, 78 & nn.41, 42 (1st Cir. 1977), *cert. denied*, 455 U.S. 980 (1978); *Insurance Commissioner v. Metropolitan Life Insurance*, 463 A.2d 793, 796 (Md. 1983); *Metropolitan Life Insurance v. Whaland*, 410 A.2d 635, 640 (N.H. 1979). In the absence of some clear indication to the contrary, it must be assumed that Congress intended to maintain state primacy in the regulation of insurance, including health insurance.

B. State Mandated Benefit Laws Are Clearly Regulations of The "Business Of Insurance" Within The Meaning Of The McCarran-Ferguson Act

Interpreting the insurance savings clause consistently with the McCarran-Ferguson Act does not transform section 514(b)(2)(A) into an exception that consumes the rule of preemption under section 514(a). Although the McCarran-Ferguson Act is broadly worded, decisions of this Court have narrowly defined the "business of insurance" to which it applies. Still, state mandated benefit laws are within the core of this definition and are therefore saved from preemption under section 514(b)(2)(A) of ERISA.

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, *supra*, the Court was presented with the question whether agreements between an insurer and certain pharmacies constituted the "business of insurance" within the meaning of McCarran-Ferguson. Under the agreements, selected pharmacies undertook to sell prescription drugs to policyholders at a fixed mark-up over the pharmacies' costs. Policyholders using the participating pharmacies paid only the amount of the mark-up (a constant charge of $2 for each prescription), with the balance being billed directly to the insurer. Although policyholders were free to use other pharmacies, the insurer discouraged them from doing so through a combination of economic and administrative disincentives.[2]

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[2] Coverage under the policies was more limited in these circumstances. Also, the insured had to first pay for the prescription in full, and then submit a claim to the insurer for reimbursement.

In rejecting the McCarran-Ferguson Act claim, the Court held that the challenged arrangements were not the "business of insurance," even though they involved insurance and were entered into by an insurer regulated by state law. The Court reasoned that the arrangements did not operate to spread risk—an "indispensible characteristic of insurance." 440 U.S. at 212. Because the insurer was already obligated to pay the covered drug benefits, the agreements with the pharmacies served only to minimize the insurer's costs. In this respect, they did not "involve any underwriting or spreading of risks, but [were] merely arrangements for the purchase of goods and services." *Id.* at 214.

The Court's conclusion was confirmed by the absence of other factors characteristic of the "business of insurance." In enacting McCarran-Ferguson, Congress was concerned with the relationship between insurers and their policyholders. *Id.* at 216-17. *See SEC v. National Securities, Inc., supra*, 393 U.S. at 460. Yet the agreements with the pharmacies defined the insurer's relationship, not with its insureds, but with providers of covered health services. 440 U.S. at 217. The Court further noted that state regulation subject to the McCarran-Ferguson Act typically applies only to entities that are within the insurance industry. 440 U.S. at 231. While the participating pharmacies were engaged in business with an insurer, they were not themselves insurers or a part of the insurance industry. *Ibid.*

Likewise, in *Union Labor Life Insurance Co. v. Pireno*, 102 S. Ct. 3002 (1982), the Court applied the same definition of the "business of insurance" to reject an insurer's claim that its use of peer review practices was exempt from antitrust challenge under the McCarran-Ferguson Act. The insurer's use of peer review did not operate to spread or underwrite risk, the Court held; the risk of loss for medically necessary treatment had already been shifted to the insurer through its policies. Moreover, the insurer's peer review practices were conducted, not by the insurer itself, but by an independent group of health care providers. Thus, the insurer's use of peer review was neither integral to the relationship between the insurer and its policyholders, *id.* at 3009, nor limited in its application to entities within the insurance industry, *id.* at 3010.

Application of these principles demonstrates that mandated benefit laws like Massachusetts' section 47B are within the core of state regulation of the "business of insurance" under the McCarran-Ferguson Act. First, and most importantly, state statutes requiring coverage for specified illnesses or disorders obviously operate to spread the risk of loss—indeed, that is their sole purpose. By mandating the provision of health benefits that otherwise would be provided at a lower level or not provided at all, mandated benefit statutes shift the risk of loss for medically necessary treatment from the individual insured to the insurer.

In addition, it is clear that mandated benefit laws directly regulate the relationship between the insurer and its policyholders. By requiring coverage for certain disorders, such laws prescribe key terms of that relationship. And finally, there can be no question that the impact of mandated benefit laws is confined to entities within the insurance industry. Although third parties may be indirectly affected by such statutes, mandated benefit laws regulate only insurers, not providers or other entities outside of the insurance industry.

This analysis would apply not only to state laws mandating coverage for mental illness, but to other mandated benefit laws as well. For example, a state statute requiring insurers to include coverage for sickle cell anemia, *see, e.g.*, Ala. Code tit. 27 § 5-13, chronic kidney disease, *see, e.g.*, Ohio Rev. Code Ann. § 392.25 (Baldwin), treatment for mastectomies, *see, e.g.*, N.H. Rev. Stat. Ann. § 1713:27-46.1a, birth defects, *see, e.g.*, Oregon Rev. Stat.

§ 743.119, or complications in pregnancy, *see, e.g.*, Idaho Code § 41-2140, would also constitute the "business of insurance" within the meaning of the McCarran-Ferguson Act.[3] As such, they too would be saved from preemption under ERISA pursuant to section 514(b)(2)(A).

To say that mandated benefit laws are saved from preemption under ERISA, however, is not to say that all state laws regulating insurers would be similarly preserved under the savings clause. Even state statutes purporting to regulate certain aspects of the content of health insurance policies would not constitute the "business of insurance" if they did not satisfy the criteria for exemption under McCarran-Ferguson. Thus, for example, many state statutes require that insurers make payments to particular types of health providers. These statutes do not require the insurer to cover a particular medical condition. Rather, they require insurers to provide payment to specified classes of health practitioners *if* those practitioners treat a condition already covered under the insurance policy.[4]

It is clear that laws of this type could not be construed as state regulations of the "business of insurance" since the mandated practices have nothing to do with the

[3] As of 1984, the statutes of 26 states mandated insurance coverage for one or more specified illnesses or procedures. These states were: Alabama, Arizona, California, Colorado, Connecticut, Idaho, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oregon, Rhode Island, Virginia, Washington, and Wisconsin. *See* Amicus Brief of Health Insurance Association of America in Support of Jurisdictional Statements at 1a-16a.

[4] Twenty-six states currently have such "mandated provider" laws. These laws require that insurers make payment to a broad range of health providers, including chiropractors, podiatrists, psychologists, optometrists and nurse midwives. *See* Amicus Brief of Health Insurance Association of America in Support of Jurisdictional Statements at 5a-16a.

spreading or underwriting of risk. By requiring that insurers provide reimbursement for the services of specified practitioners, these statutes do not shift the risk of loss from policyholders to the insurer. As in the case of the pharmacy agreements in *Group Life & Health Insurance Co. v. Royal Drug Co., supra*, and the peer review procedures in *Union Labor Life Insurance Co. v. Pireno, supra*, the insurer is already obligated to pay for such losses up to the limits of its policies. Mandated provider laws simply regulate the relationship between the insurer and certain categories of providers—parties wholly outside the insurance industry.[5]

In sum, interpreting ERISA's savings clause as incorporating the McCarran-Ferguson Act's exemption for the "business of insurance" demarcates a permissible zone of state insurance regulation that is both narrowly circumscribed and well-defined. Under this approach, laws relating to insurance are not saved from preemption simply because they purport to regulate insurers or insurance policies. The permissible zone of state regulation is thus more limited than would be the case under appellee's interpretation of section 514(b)(2)(B). At the same time, this approach would not impose on the states the straitjacket proposed by appellant. As we now show, appellant's analysis of ERISA's savings clause does not withstand scrutiny.

[5] For this reason virtually every court that has considered the question has concluded that the McCarran-Ferguson Act does not extend to decisions of insurers to restrict the range of health providers entitled to receive direct payment for covered health services. *See Klamath-Lake Pharmacy v. Klamath Medical Services Bureau*, 701 F.2d 1276 (9th Cir.), *cert. denied*, 104 S. Ct. 88 (1983); *Hahn v. Oregon Physicians' Service*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 103 S. Ct. 3115 (1983); *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied* 450 U.S. 916 (1981); *Trident Neuro-Imaging Laboratory v. Blue Cross and Blue Shield of South Carolina*, 568 F.Supp. 1474 (D.S.C. 1983).

C. Application of McCarran-Ferguson Act Principles Makes Far More Sense Than Appellant's Approach

Appellant's interpretation of ERISA's savings clause is predicated, not on Congressional intent with respect to that clause, but on the purposes and policies underlying the basic preemption provision of ERISA, section 514(a). We have already pointed out that Congressional intent with respect to section 514(a) is of little usefulness in interpreting a savings clause which, by its terms, is intended to limit the reach of the preemption provision. However, even if the purposes behind section 514(a) were a guide to the interpretation of the savings clause, they do not lead to the conclusion that appellant wishes the Court to reach.

Metropolitan stresses that one of Congress' main objectives in providing for the preemption of state law in ERISA was to foster uniformity in the design of employee benefit plans. This much is clearly correct. *See Shaw v. Delta Airlines Inc., supra*, 103 S. Ct. at 2903. Appellant argues that state mandated benefit laws are inconsistent with this objective in two respects. First, they create "disuniformity" in the insured plans of multistate employers who must comply with the potentially divergent mandated benefit laws of different states. Second, appellant argues that, because ERISA's "deemer" provision precludes direct state regulation of employee benefit plans, mandated benefit laws create disuniformity between regulated and self-insured plans within the same state.

Under appellant's theory, all mandated benefit laws are preempted by section 514(a). At the same time, however, Metropolitan concedes—as it must—that ERISA does *not* preempt certain other types of state regulation of insurance that are designed to protect policyholders and to ensure the solvency of insurers. State laws of this type constitute regulation of the "business of insurance" within the meaning of the McCarran-Ferguson Act. *See*

SEC v. National Securities Inc., supra, 393 U.S. at 459-61. They include, according to appellant, state laws prescribing the level of reserves that insurers must maintain and state laws regulating insurers' premium rates. Brief of Metropolitan Life Insurance Co. at 34-35.

Appellant's argument proves too much. Whatever the extent of these disuniformities—and we believe that they are exaggerated [6]—it is evident that the potential for significant disuniformities is already created by the "traditional" forms of state regulation that appellant acknowledges are saved from preemption. For example, depending on the degree of variation among states, regulation of insurance premiums may require multistate employers to provide very different types and levels of coverage for employees in different states. The provision of uniform coverage in such circumstances would force employees in the low premium states to subsidize the coverage of employees in the high premium states.

The same is obviously true with respect to state regulations governing insurers' reserves. Insurance reserve accounts—which are held against future claims—are funded by the excess of premiums collected over actual claims paid (plus the insurer's costs and profit). The level of reserves required by state regulations plainly has a direct bearing on a plan's premium rates and benefits. A multistate employer doing business in states prescribing different reserve requirements cannot efficiently provide the same insurance policy for all employees. Premium levels and coverage (or both) will vary, unless employees in the states prescribing low reserve require-

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[6] It is significant that at trial appellant made little effort to prove the extent of any costs attributable to the disuniformities. See Brief of Appellee Opposing Jurisdictional Statements at 5-6. In its merits brief to this Court, Metropolitan is careful to claim only that "[a]t trial, defendants *stressed* that mandated benefit statutes" create costly disuniformities among plans. Brief of Metropolitan Life Insurance Co. at 6 (emphasis added).

ments subsidize employees in the states requiring higher reserves.

These same concededly *permissible* regulations of insurance also have the potential for creating substantial disuniformities between plans within the same state. Because of ERISA's "deemer" provision forbidding direct state regulation of employee benefit plans, section 514 (b)(2)(B), state regulations pertaining to premium rates or reserve requirements cannot be applied to self-insured plans. Metropolitan repeatedly argues that Congress could not have intended the preservation of assertedly burdensome state regulation that encourages employers to self-insure. Under appellant's own theory, however, states will continue to have the regulatory authority to create precisely this incentive.[7]

Whether these other types of disuniformity are a good or bad thing is not the point here. All we mean to say is that substantial disuniformities may be created by the very types of state regulation that appellant acknowledges are *not* preempted by ERISA. It follows that any disuniformities that might be created by state mandated benefit laws *cannot* be a sufficient basis for concluding that those laws are preempted by section 514(a).

Moreover, it is extremely unlikely that, in enacting ERISA, Congress intended to create a regulatory vacuum as complete as that urged by appellant. Although ERISA

[7] A further source of disuniformity between insured and self-insured plans is created by state premium taxes applied to commercial health insurers in most states. See J. Meyer, "Health Care Competition: Are Tax Incentives Enough?" in *A New Approach to the Economics of Health Care* 424 (1981). It has been estimated that these taxes can effectively increase an insurer's costs (relative to an exempt nonprofit or self-insured plan) by as much as 20 to 30 per cent. H. Frech, "Blue Cross, Blue Shield and Health Care Costs: A Review of the Economic Evidence" in *National Health Insurance: What Now? What Later? What Never* 250, 251-52 (1980).

applies substantive requirements to pension and retirement plans, no such standards are imposed on health insurance policies; only the statute's fiduciary and reporting requirements apply to employee benefit plans. ERISA §§ 201(1), 301(a)(1), 29 U.S.C. §§ 1051(1), 1081(a)(1). *See* Hutchinson & Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 Chicago L. Rev. 23, 30 (1978). Because no other federal laws regulate the content of insurance policies, appellant's theory yields the result that health insurance policies are simply exempt from any regulation of their substantive content.

If Metropolitan's theory prevails, there will be nothing to prevent insurers from offering wholly inadequate health coverage in group insurance policies. *See generally*, K. Davis, *National Health Insurance: Benefits Costs and Consequences* 34-41 (Brookings, 1975). Insurers would be free to curtail or eliminate catastrophic protection, leaving policyholders without coverage after the first few days of extended hospitalization. Policyholders could discover that, because of hidden exclusions, "preexisting condition" limitations, coinsurance requirements or other restrictions, their policies do not provide the coverage they thought they had.

It may be argued that this is not a valid concern because the ordinary functioning of the market for health insurance—a market that is admittedly competitive in many respects—will assure that such abuses do not occur. This argument, however, overlooks the fact that, by and large, the purchasers of group health insurance policies are not individual policyholders acting in their own self-interest, but employers. While most employers can be expected to act as proxies for their employees, it cannot be assumed that all will. Undoubtedly, some employers will purchase inadequate insurance as a means of minimizing costs.

Seen in this light, ERISA's disparate treatment of self-funded employee benefit plans and insured plans is not anomalous at all. While preserving state regulation of the content of insured plans, Congress entrusted to market forces the regulation of self-funded plans. It is reasonable to think that the need for regulation is much greater for the former than for the latter. Because of union representation and other factors,[8] businesses large enough to self-insure are likely to provide adequate health insurance without government regulation. Businesses too small to self-insure, by contrast, are likely to have a freer hand in the design of insurance coverage for their employees.[9]

In sum, there is no merit to appellant's analysis of ERISA's savings clause. ERISA plainly contemplates disuniformities among employee benefit plans as well as disparate treatment of self-funded and insured plans. What ERISA clearly does *not* contemplate is the creation of a regulatory void in which no jurisdiction—state or federal—oversees the content of health insurance policies to assure that policyholders are not faced with devastating losses due to inadequate coverage.

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[8] Self-insured companies that are not unionized frequently have avoided unionization because they offer favorable employee benefits, including health insurance policies. Companies of that size are also more likely to have skilled workers who are not readily replaceable in the event of disabling illness. Such businesses may calculate that, by reducing illness-related productivity losses, comprehensive health insurance is a good investment.

[9] This generalization has been borne out in the mental health field. A 1983 study of employers in major industries concluded that self-insured plans were more likely than insured plans to provide mental health coverage comparable to that provided for physical illness. S. Muszynski, J. Brady & S. Sharfstein, *Coverage for Nervous and Mental Disorders: Summaries of 300 Private Sector Health Plans* 16-17 (1983).

II. MANDATED BENEFIT LAWS ARE NECESSARY TO CORRECT FOR "MARKET FAILURE" IN THE MARKET FOR HEALTH INSURANCE

Appellant characterizes mandated benefit laws as dispensable economic legislation that, by altering the health coverage that would be offered in an unregulated environment, serve no valid purpose. The argument is simply wrong. As we show, mandated benefit laws represent a highly desirable form of government intervention necessary to correct for "market failure" in the market for health insurance.

We start with two propositions. The first is that the states have a strong interest in assuring that their citizens have minimally adequate health insurance. Because of the high cost of medical care, underinsured persons suffering catastrophic illness may face staggering financial losses. Few families have the means to absorb such costs, with the result that many patients afflicted with serious illness requiring extended treatment may be unable to obtain it. To the extent such persons can find free or subsidized care, they impose substantial economic burdens on private and public health facilities. *See* Congressional Budget Office, *Catastrophic Medical Expenses: Patterns in the Non-Elderly, Nonpoor Population* (1982). Mandated benefit laws protect against these dislocations by requiring insurers to provide adequate protection.

The second proposition is that insurance providing substantially less coverage than that required by mandated benefit laws will produce precisely these types of dislocations. For example, several states require coverage for complications in pregnancy, *see, e.g.*, Cal. Ins. Code § 10119.5 (West), and birth defects, *see, e.g.*, Oregon Rev. Stat. § 743.119. Insurance not providing such coverage would expose insureds to thousands of dollars in unreimbursed medical bills. The same is true with respect to state laws mandating coverage for mastectomies, *see, e.g.*, N.H. Rev. Stat. Ann. § 1713:27-46.1a,

sickle cell anemia, Ala. Code tit. 27 § 5-13, or reconstructive surgery, *see, e.g.*, Minn. Stat Ann. § 62A.25 (West). In the case of mental illness, patients requiring hospitalization for only twenty or thirty days beyond the coverage limits of their policies would face bankrupting costs.[10]

The risk that insurers will provide inadequate levels of health protection in the absence of government regulation is particularly great with respect to mental health treatment. This is so because insurers' decisions about whether to offer such coverage, and consumers' decisions about whether to purchase it, are seriously skewed by distortions in the market for health insurance that prevent the underwriting of significant health risks. As explained below, the market for health insurance covering mental illness is a classic case of market failure for which government intervention in the form of mandated benefit laws is plainly appropriate.[11]

A. Lack of Information

Market failure in this area derives from several distortions. The first, and most important, is a lack of information in the hands of consumers concerning the risks

[10] Long-term hospitalization is not uncommon in the treatment of acute mental illness. In 1975, 34 percent of all persons admitted to private psychiatric hospitals were hospitalized for more than 29 days. *See* National Institute of Mental, *Characteristics of Admissions to Selected Mental Health Facilities, 1975, Mental Health Service System Reports No. 2* (1981). Hospitalizations are longest in the case of childhood psychiatric disorders. In 1975 the *median* stay in a private psychiatric hospital for such treatment was 40.6 days. *Ibid.*

[11] This is not to say that every mandated benefit law covering mental illness necessarily prescribes an appropriate level of coverage. Because *de jure* minimums often become *de facto* maximums, the coverage requirements of such statutes should be set to fully correct for market distortions.

of severe mental illness requiring costly and extensive treatment. T. McGuire, *Financing Psychotherapy: Costs, Effects and Public Policy* at 61 (1981). Responding to market forces, an insurer provides the types and levels of health coverage that consumers want, based on their perceptions of the risks associated with particular medical conditions. In the case of mental illness, most purchasers of health insurance, whether individuals or employers, seriously underestimate the risks involved. Believing—erroneously—that the risk of mental disease is far below that of physical illness, they undervalue mental health coverage in the market.

In fact, the incidence of severe mental illness, such as manic depression, schizophrenia, and other psychotic disorders, is generally comparable to the incidence of cancers and heart disease—medical conditions for which complete insurance coverage is usually thought to be indispensable. In 1980 the number of admissions to hospitals throughout the United States for treatment of mental disorders was approximately 1.69 million, or 75.9 admissions for every 10,000 persons. Department of Health and Human Services, *Utilization of Short-Stay Hospitals: Annual Summary for the United States, 1980, National Health Survey Series 13* at 34-35 (March 1982). The incidence of cancer and heart disease were of the same order of magnitude. For malignant neoplasms of all types, the number of hospital admissions was 1.82 million, or 82 admissions per 10,000 population. For all types of heart disease, hospital admissions totalled 3.2 million. *Ibid.*

The prevalence of severe mental illness is even more striking when specific mental disorders are compared with specific forms of physical illness. For instance, the number of hospitalizations in 1980 for the treatment of psychotic illnesses was 507,000. *Ibid.* Comparable figures for selected physical conditions were as follows: acute myocardial infarction, 431,000; congestive heart failure, 401,000; ulcers of the stomach and small intes-

tine, 363,000; and infectious diseases, 649,000. *Ibid.* For the treatment of all types of leukemia, there were 53,000 hospital admissions in the United States in 1979. Department of Health and Human Services, *Detailed Diagnoses and Surgical Procedures for Patients Discharged from Short-Stay Hospitals, 1979* at 16, 307 (January 1982). The risks of severe mental illness are thus fully comparable to those of physical illnesses for which adequate insurance is universally available.

The widespread misapprehension of the risks of mental illness is perhaps best illustrated by statistics pertaining to suicide among adolescents. In 1980, 5381 children and teenagers died from suicide—the third leading cause of death for persons in this age group. *See* Department of Health and Human Services, *Data From the National Center for Health Statistics*, 30 Monthly Vital Statistics Report 21 (December 20, 1982). Although precise figures are not available, it can be assumed that many more adolescents, suffering from depression or other serious illnesses, made unsuccessful suicide attempts.[12] By contrast, the number of hospitalizations for acute lymphoid leukemia, the type of leukemia that strikes mainly children, was approximately 9,000 in 1979. Department of Health and Human Services, *Detailed Diagnoses and Surgical Procedures for Patients Discharged from Short-Stay Hospitals, 1979* at 307 (January 1982). Most families would find unacceptable an insurance policy that offered little or no coverage for this type of cancer. Yet, because of incomplete information, the same consumers undervalue psychiatric coverage for their children.

The market distortion of incomplete information concerning the risks of mental illness is compounded by the

[12] Medical experts generally assume that the number of unsuccessful suicide attempts are fifty to a hundred times greater than the number of completed suicides. See M. McIntire, C. Angle & M. Schlicht, "Suicide and Self-Poisoning in Pediatrics," 24 Advances in Pediatrics 291 (1977).

stigma that many people associate with mental illness. S. Sharfstein, S. Muszynski & E. Myers, *Health Insurance and Psychiatric Care: Update and Appraisal* 52 (1984). Even persons who are aware of the general risks of mental disease may discount those risks with respect to themselves or their families. *See* Brown, "The Life of Psychiatry," 133 Journal of American Psychiatry 489 (1976). Because of the moral opprobrium that society continues to attach to psychiatric illness, many consumers are unwilling to acknowledge the fact that mental illness, like physical illness, can strike randomly; they believe the statistical probabilities apply only to others.

For these reasons, insurers as a group are unlikely to offer adequate levels of mental health coverage in an unregulated environment. Responding to market forces, most insurers will not offer coverage that consumers do not demand, irrespective of the magnitude of the health risks that go uncovered. Moreover, a second distortion in the health insurance market reinforces this problem by assuring that, once the pattern of inadequate coverage is established, no single insurer can deviate from it. This second market distortion is known as "adverse selection."

B. Adverse Selection

All health insurance plans spread the risk of loss due to illness by having substantially more "good risk" subscribers than "bad risk" subscribers. As the term suggests, adverse selection occurs when a particular plan is selected by a disproportionate number of bad risks. To pay the increased claims generated by these bad risk subscribers, the plan must raise its premium rates to all subscribers. This causes some good risks to leave the plan to obtain lower cost coverage elsewhere. Their departure, in turn, forces the plan to raise premiums still higher, thus causing more of the good risk subscribers to leave the plan. *See* A. Donabedian, *Benefits in Medical Care Programs* 354-58 (1970); T. McGuire, *Financing Psy-*

chotherapy: Costs, Effects, Public Policy, supra, at 44-51. If unchecked, the spiraling effect of adverse selection can destroy an insurance plan.

Adverse selection makes the market failure for mental health insurance complete by preventing any individual insurer from breaking ranks with its competitors to offer adequate coverage. Even an insurer that recognizes the need for this coverage, and wishes to offer it, would quickly conclude that the risks were prohibitive. It would calculate that, by increasing coverage in this area, the plan's costs would go up as existing bad risk subscribers use the coverage and new bad risks migrate to the plan. The premium rate increases necessary to cover these costs would then drive good risks out of the plan to competing insurers able to offer more favorable premiums.[13]

The threat of adverse selection is not confined to mental health coverage. A disproportionate number of subscribers who are bad risks with respect to heart disease, cancer or other illness will similarly cause good risks to leave an insurance plan. However, the exodus of good risks from a plan that is adversely selected on the basis of its mental health coverage will be accelerated by the fact that mental health coverage is an insurance benefit that most good risks do not want. As discussed earlier,

[13] This scenario is not merely hypothetical. In 1973 one of the insurance plans offered to federal employees as part of the Federal Employees Health Benefits Program unilaterally raised its coverage for mental illness. Because of an influx of bad risk subscribers and a loss of good risks, the plan was forced to rescind these benefit increases. *See* McGuire, *supra,* at 49-50. Adverse selection in mental health coverage afflicted a second plan in the federal program in the early 1980s, causing it too to make major reductions in benefits. *See* S. Sharfstein & C. Taube, "Reduction in Insurance for Mental Disorders: Adverse Selection, Moral Hazard and Consumer Demand," 139 American Journal of Psychiatry 1425, 1426-27 (1982).

such persons underestimate the risk of mental illness for themselves and their families and, as a result, undervalue mental health coverage in their selection of insurance.

C. The "Free Rider" Problem

A third type of market failure preventing the underwriting of the risk of mental illness is created by state-operated and state-funded facilities and programs for the mentally ill. These facilities and programs, which include state mental hospitals, community mental health centers, nursing homes and other day and outpatient treatment programs, provide care that is either free or heavily subsidized. The very existence of this system distorts the insurance market by diminishing the value of coverage for mental illness. Why purchase insurance coverage for mental illness (or pay the full price for it) when the state will provide treatment for free? Even if the state-provided care is of lesser quality, its availability reduces the utility of private insurance in the eyes of employers and policyholders.

State mental health systems thus create a classic "free rider" problem. The states have a legitimate interest in limiting the use of these facilities to patients too poor to afford insurance for the treatment of mental illness. Other than through the regulation of insurers, however, states have no mechanism for enforcing this limitation. As the health care provider of last resort, the state must provide medical treatment to patients who need it and have no means to pay for it. This situation is exploited by insurers and insureds who, by underinsuring for mental illness, shift the cost of necessary medical treatment to the state-supported health care system.[14]

[14] This problem is especially acute for the states because Medicare and Medicaid, the principal health insurance programs funded by the federal government, provide only limited coverage for mental illness.

The market for insurance covering mental illness is thus seriously distorted by three types of market failure—lack of information concerning the risks of mental disease, adverse selection, and the "free rider" effect of state-operated and funded health programs. Any one of these distortions creates an unacceptable risk that the insurance market will consistently misallocate health protection in this area—that is, that insurers will not underwrite risks of loss for which the alternative of self-insurance is not possible. The combination of these three types of market failure virtually guarantees that this will be the case. In the absence of regulation, insurers operating in a competitive environment will not offer adequate levels of coverage for severe mental illness.

Mandated benefit laws attempt to correct these market failures by requiring insurers to offer acceptable levels of health coverage. It is no objection to these statutes that they override the decisions of employers about the amount and type of insurance to provide. Brief of Metropolitan Life Insurance Co. at 27-31. That argument misses the point. Where the "choices" made by the market are seriously distorted by market failure, there is no reason to validate those distortions under the guise of preserving "free choice."

From both an economic and social standpoint, it is hard to imagine a more compelling case for government regulation than the market for health insurance covering mental illness. State authority to mandate acceptable levels of coverage in this area should not be disturbed.

CONCLUSION

The judgment of the Massachusetts Supreme Judicial Court should be affirmed.

Respectfully submitted,

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